Confidential Child Information Form

Patient Name_____

Parents / Guardians Names _____

Address_____

Email _____ Birth Date _ _ / _ _ / _ _

Mobile Number _____ Home _____ Work _____

Sex _____ Weight _____ Height_____

Who Were You Referred by? □Friend, □ Family, □ Health Workshop, □ Locality, □ Advert,

□ Website, □ Yellow Pages, □ Dentist, □ Maternal Child Health Nurse, □ Other:_____

THE REASON WHY YOU ARE HERE TODAY?_____

Other Doctors seen Y [ ] N [ ] Doctors Name / Prior Treatment_____

Other Health Problems ? _____

Check the following problems your child has suffered from in the past 12 months :

[ ] ear infections [ ]scoliosis [ ]seizures [ ] chronic colds [ ] headaches

[ ] asthma/allergies [ ] digestive problems [ ] ADHD [ ] recurring fevers

[ ] growing/back pains [ ]colic [ ]bed wetting [ ] car accident [ ] bad temper

[ ] moodiness [ ]other _____

FAMILY HISTORY : _____

PREVIOUS CHIROPRACTOR (IF ANY) _____

Date of last visit _ _ / _ _ / _ _ Reason _____

Name of GP _____

Date of last visit _ _ / _ _ / _ _ Reason_____

Are you satisfied with the care your child received there ? Y [ ] N [ ]

Number of doses of Antibiotics your child has taken ?

last 6 months _____ Lifetime _____

Number of other medications your child has taken ?

last 6 months _____ Lifetime _____

Vaccination History : _____

PRE NATAL HISTORY:

Name of Obstetrician/ Midwife : _____

Complications during pregnancy Y_____ N_____ List _____

Ultrasound during pregnancy Y_____ N _____ Number : _____

Medications during pregnancy / Delivery Y_____ N _____ List :

_____

Cigarette / Alcohol use during pregnancy Y _____ N _____

Location of birth : Hospital_____ Birthing Centre _____ Home _____

BIRTH INTERVENTION:
Caesarean section : planned [ ] emergency [ ]
Forceps extraction [ ] Vacuum extraction [ ]
Complications during delivery Y_____ N_____ List : _____
Genetic disorders or disabilities Y _____ N _____ List : _____
Birth weight : _____ Birth length : _____

FEEDING HISTORY :
Breast fed : Y_____ N _____ How long _____
Formula fed : Y _____ N _____ How long _____
Introduction to solid foods _____ months Cows milk at _____ months
Food / Juice allergies or intolerances : Y _____ N _____ List :
_____

DEVELOPMENTAL HISTORY :
During the following times your child's spine is most vulnerable to stress and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxations (spinal nerve interference). At what age was your child able to:
Respond to sound _____ Respond to visuals _____
Hold head up _____ Sit up _____ Cross crawl _____
Stand Alone _____ Walk alone _____
According to the National Safety Council approximately %50 of children fall head first from a high place during their first year of life. (bed, changing table, down stairs)
Was this the case with your child Y_____ N _____
Is / Has your child been involved in any high impact or contact sports Y ____ N ____
List : _____
Has your child ever been in a car accident Y_____ N _____ How many _____
Has your child ever been seen for an emergency Y _____ N _____ List :
_____
Other traumas not listed : _____
Prior Surgery : _____
Menarche Y _____ N _____ Age : _____

CHILDHOOD DISEASES :

Chicken Pox	Y / N	Age_____	**Rubella**	Y / N	Age _____
Rubeola	Y / N	Age_____	**Mumps**	Y / N	Age _____
Whooping Cough	Y / N	Age_____	**Other**	Y / N	Age _____

WE ARE HERE TO SERVE YOU, AND ENCOURAGE YOU TO ASK QUESTIONS. YOUR PARTICIPATION IS VITAL AND WILL HELP DETERMINE YOUR RESULTS.

AUTHORIZATION FOR CARE OF MINOR

I hereby authorize this office and its Doctors to administer care to my son / daughter as they deem necessary.
I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

_____	_____	_____
SIGNED	NAME	DATE